5/3/

16-1-01

PRINTED: 03/31/2021 FORM APPROVED OMB NO. 0938-0391

STATE!		CIENCIE
		W

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION
A. BUILDING

(X3) DATE SURVEY COMPLETED

15th 15th

NAME OF PROVIDER OR SUPPLIER

445203

B. WING

03/23/2021

WEST MEADE PLACE

STREET ADDRESS, CITY, STATE, ZIP ÇODE 1000 ST LUKE DRIVE

NASHVILLE, TN 37205

(X4) ID

PRÉFIX

TAG

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LSC IDENTIFYING INFORMATION)

ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY)

(X5) COMPLETION DATE

F 000 INITIAL COMMENTS

Complaint investigation #TN00052145, #TN00053468, and #TN00053509 were completed on 3/23/2021 at West Meade Place. No deficiencies were cited related to complaint investigation #TN00052145 and #TN00053468. Unrelated defencicies were cited related to complaint investigation #TN00053509 under 42 CFR PART 483, Requirements for Long Term Care Facilities.

F 684 Quality of Care SS=D CFR(s): 483.25

§ 483.25 Quality of care

Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: F684

Based on facility policy review, medical record review, observations and interviews, the facility failed to follow Physician's orders for 1 (Resident #2) of 3 residents reviewed. The facility also failed to turn and reposition 1 (Resident #2) of 3 residents reviewed.

Review of facility Prevention Guidelines dated 1/1/03, showed,"...Reduce prolonged pressure while in bed or up in chair. Reposition at least q

F 000 This Plan of Correction is submitted as required by State & Federal Law and does not constitute an admission on the part of the facility, that the findings constitute a deficiency or that the scope and severity regarding the deficiencies are correctly applied.

F 684

See Attachment A



LABORATURY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

ADMINISTRATOR

4-9-21

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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DEPAR	KIMENT OF HEALTH	AND HUMAN SERVICES			FOR	M APPROVEI
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO	O. 0938-039
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				1000 ST LUKE DRIVE		
WEST N	MEADE PLACE			NASHVILLE, TN 37205		
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F 684	Continued From page (every) 2 hours while when up in chair"	ge 1 e in bed and more frequently	F 684			
	revised 11/17, show support the patient/r environment which i strive to cultivate an of life for each indivi care and services, b	licy titled, "Resident Rights," ed, "At [named facility] we resident's right to live in an s individualized for them. We d sustain an excellent quality dual with person-centered by honoring and supporting t's preferences, choices,				
	#1 was admitted to t readmitted on 6/29/2 included Neuromyeli Chronic Respiratory Obstructive Sleep Ap Depressive Disorder	al record showed Resident he facility on 11/26/2019 and 2020 with diagnoses which tis Optica (Devic), Acute and Failure with Hypoxia, onea, Tracheostomy, Major , Generalized Anxiety idence on Respirator.				
	assessment dated 1/ had a Brief Interview score of 15, which in- impairment. Also doc	sumented was the need for ance with bed mobility and				
	Dovinu of the madies	al record showed Pasident				

#2 was admitted to the facility on 2/6/2020 with diagnoses which included Chronic Respiratory

Event ID: D0B811

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OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		(X3) DATE SURVEY COMPLETED
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ADE PLACE			NASHVILLE, TN 37205	
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
	OF DEFICIENCIES CORRECTION ROVIDER OR SUPPLIER ADE PLACE SUMMARY STA (EACH DEFICIENCY	CORRECTION IDENTIFICATION NUMBER: 445203 ROVIDER OR SUPPLIER	OF DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULT A, BUILDI 445203 B, WING ROVIDER OR SUPPLIER ADE PLACE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X2) MULT A, BUILDI	CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A, BUILDING B, WING STREET ADDRESS, CITY, STATE, ZIP CODE 1000 ST LUKE DRIVE NASHVILLE, TN 37205 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X2) MULTIPLE CONSTRUCTION A, BUILDING B, WING STREET ADDRESS, CITY, STATE, ZIP CODE 1000 ST LUKE DRIVE NASHVILLE, TN 37205 PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL) PREFIX (EACH CORRECTIVE ACTION SHOUL) TAG CROSS-REFERENCED TO THE APPROVIDER'S PLAN OF CORRECT IN SHOUL)

F 684 Continued From page 2

status, Anoxic Brain Damage, Epilepsy, Dysphagia, Pressure Ulcer of Sacral Region, Stage 4, Hemiplegia and Hemiparesis following Cerebral Infarction, Type 2 Diabetes Mellitus with Chronic Kidney Disease, and Pulmonary Hypertension.

Review of the Annual Comprehensive MDS assessment dated 2/10/2021, showed Resident #2 was unable to complete the interview on the BIMS, indicating severely impaired cognition.

Review of Resident #2's Physician Order Report dated 3/22/2021 showed, "...5/15/2020 Dental Guard: Resident to have dental guard in place each shift. Special Instructions: Resident has two dental guards. Resident to alternate each dental guard every 6 hours, Mouth Guard to be cleaned every 6 hours...2/22/2021 Contact Isolation for ESBL in Sputum contact isolation for ESBL [Extended Spectrum Beta-lactamases] in wound...7/27/2020 Strict Contact - r/t (related to) ESBL in urine. All care and treatment provided in patients private room/semi private room with no roommate...12/30/2021 TURN & REPOSITION Q 2 HOURS FOR DECUBITUS CARE!!! PER [named physician] Every 2 hours; 06:00 AM, 08:00 AM, 10:00 AM, 12:00 PM, 02:00 PM, 04:00 PM, 06:00 PM, 08:00 PM, 10:00 PM, 12:00 AM, 04:00 AM...2/12/2021 PLEASE KEEP PATIENT'S BILATERAL FEET FLOATED AT ALL TIMES!...1/08/2021 Apply skin prep to right medial foot resolved blister daily... Ensure patient is wearing pressure relieving boots bilaterally..."

F 684

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES	,)	OMB N	O. 0938-0391	
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F 684	Continued From page	ge 3	F 6	34				
	Review of the medic	cal record showed Resident						
	#3 was admitted to	the facility on 5/16/2012 wich						
		nosis Thoracolumbar Region, aplegia, Osteoporosis,						
		Chronic Kidney Disease.						
		r						
		luled 5 day MDS assessment howed Resident #3 had a						
		hich indicated the resident is						
		so documented was her						
	mobility and reposition	maximum assistance for bed onling.						
	,							
	During observations	on Resident #2 on 3/22/2021						
		, 3:58 PM, 4:15 PM, 5:06 PM						
		d her lying on her left side urther observation on						
	3/23/2021 at 08:59 A	M and 11:00 AM, showed						
	her lying on her right	side. There was a dental edside table. She did not						
	have heel boots on, a							
	positioned on a pillov	v. There were no isolation						
	precautions in place	and she had a roommate.						
1	During an intantion o	n 3/22/2021 at 5:58 PM with						
		ng, she confirmed residents						
1	who are immobile an	d unable to reposition						
	hemselves in bed, m at least every 2 hours	ust be repositioned by staff						
•	at least every 2 nours	,,						

During an interview on 3/23/2021 at 1:54 PM with

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F 710	room, the DON con have a mouth guard heels were not float on bilateral heel bod isolation and she had of Nursing confirme had Physician's Ord guard and for heel bid discontinued when the orders, and they	ing (DON) in Resident #2's firmed the resident did not I in her mouth, the resident's ed, the resident did not have ots, the resident was not in d a roommate. The Director d, "[named] Resident #2 ers for isolation, a mouth oots which should have been he resident no longer needed were not"	F 6		See Attachment B		
	A physician must per recommendation that a facility. Each residence of a physician assistant, nurse praces specialist must provision mediate care and \$483.30(a) Physician The facility must ensigned by a physicial care of residence of residence of the supervised by a physician is unavailal	rsonally approve in writing a at an individual be admitted to lent must remain under the A physician, physician stitioner, or clinical nurse de orders for the resident's needs. I Supervision, ure that-edical care of each resident ysician; er physician supervises the ents when their attending					

Based on medical record review, observations

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION		DATE SURVEY COMPLETED
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F 710	Continued From pa	ge 5	F 7	10			
	·	facility failed to obtain	. ,	. •			
		or specialty air mattresses					
		(Residents # 1,#2, #3, #8, #9,					
		#14, #15, #16, #17, #18, #19, #24, #25, #26, #27, #28, #29,					
		#34, #35, #36) of 32					
	residents reviewed.	, ,					
	The findings include	:					
	Pavious of the modic	al record showed Resident					
		he facility on 11/26/2019 with					
	readmission on 6/29	/2020 with diagnoses which					
		tis Optica, Acute and Chronic					
	Mellitus, and Obesity	with Hypoxia, Type 2 Diabetes					
	Telemicae, and obcort	•					
	Daview of Deside 4	#41a Dhuaisian O-day Danast			20		
		#1's Physician Order Report wed Resident #1 had no					
		air mattress with settings.					
	•						
	During an observation	n on 3/23/2021 at 3:01 PM					
		had a specialty air mattress					
	in place.						
		al record showed Resident					
		e facility on 2/6/2020 with					
		uded Chronic Respiratory Damage, Personal History					
		rest, Type 2 Diabetes					
	Mellitus, Anemia, and						
							1

Review of Resident #2's Physician Order Report

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MUL' A BUILDI	TIPLE CONSTRUCTION ING		DATE SURVEY COMPLETED
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F 710		ge 6 owed Resident #2 had no air mattress with settings.	F 7 ⁻	10		
		on on 3/23/2021 at 3:02 PM 2 had a specialty air mattress				
	#3 was admitted to to diagnoses which incomic Kidney Dise	cal record showed Resident the facility on 5/16/2012 with sluded Spinal Stenosis, ease, Iron Deficiency Anemia, of Sacral Region, Stage 4.				
	dated 3/23/2021 sho	#3's Physician Order Report wed Resident #3 had no r mattress with settings.				Î
		on on 3/23/2021 at 3:03 PM had a specialty air mattress				
:	#8 was admitted to tl readmission on 2/27/ included Hypertensiv Failure, Muscle Wea	al record showed Resident ne facility on 1/27/2021 with /2021 with diagnoses which re Heart Disease with Heart kness, Chronic Obstructive Type 2 Diabetes Mellitus, knemia.				
		8's Physician Order Report wed Resident #8 had no				

order for a specialty air mattress with settings.

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938-039
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NAME OF	PROVIDER OR SUPPLIER	ž.		STREET ADDRESS, CITY, STATE, ZIP COD	
WEST M	MEADE PLACE			1000 ST LUKE DRIVE NASHVILLE, TN 37205	
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F 710	Continued From pa	ge 7	F 710	0	
		ion on 3/23/2021 at 3:04 PM 8 had a specialty air mattress			
	9 was admitted to the readmission on 10/1 included Chronic Kid	cal record showed Resident # ne facility on 8/5/2014 with 10/2015 with diagnoses which dney Disease, stage 4, nd Vitamin D Deficiency.			
	dated 3/23/2021 sho	#9's Physician Order Report owed Resident #9 had no air mattress with settings.			
		on on 3/23/2021 at 3:05 PM had a specialty air mattress			
; !	#10 was admitted to diagnoses which incl	ral record showed Resident the facility on 12/4/2020 with luded Multiple Fractures of ness, and Age-Related			
	dated 3/23/2021 show	#10's Physician Order Report wed Resident #11 had no r mattress with settings.			
		n on 3/23/2021 at 3:06 PM 0 had a specialty air mattress			

in place.

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F 710	Continued From pa	ge 8	F 7′	0			
	#11 was admitted to diagnoses which ind Pulmonary Disease	with Hypoxia, Epilepsy, I Chronic Diastolic					
	dated 3/23/2021 sho	#11's Physician Order Report owed Resident #11 had no air mattress with settings.					
		on on 3/23/2021 at 3:07 PM 1 had a specialty air mattress					
	#12 was admitted to diagnoses which incl Disease, Chronic Atri	al record showed Resident the facility on 1/30/2018 with uded Acute Respiratory ial Fibrillation, Type 2 d Chronic Kidney Disease,					
(dated 3/23/2021 show	12's Physician Order Report wed Resident #12 had no air mattress with settings.					
S		n on 3/23/2021 at 3:08 PM had a specialty air mattress					

Review of the medical record showed Resident

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		445203	B. WING		C 03/23/2021
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 ST LUKE DRIVE NASHVILLE, TN 37205	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI ((EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 710	readmission on 1/29 included Acute and Anemia, Dependent Obstructive Pulmon Mellitus, and Non-pu	the facility on 4/23/2020 with 9/2021 with diagnoses which Chronic Respiratory Failure, ce on Renal Dialysis, Chronic ary Disease, Type 2 Diabetes ressure Chronic Ulcer of Skin.	F7	10	
	dated 3/23/2021 sho order for a specialty During an observation	#13's Physician Order Report owed Resident #13 had no air mattress with settings. on on 3/23/2021 at 3:09 PM 3 had a specialty air mattress			
	#14 was admitted to with readmission on which included Chro Hypercapnia, Chroni	al record showed Resident the facility on 11/20/2020 1/15/2021 with diagnoses nic Respiratory Failure with c Obstructive Pulmonary Renal Disease, and Chronic e) Heart Failure.			
	dated 3/23/2021 sho	#14's Physician Order Report wed Resident #14 had no air mattress with settings.			
		n on 3/23/2021 at 3:10 PM *4 4 had a specialty air mattress			
	Review of the medica	al record showed Resident			

#15 was admitted to the facility on 2/25/2020 with

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CENTE	RS FOR MEDICARI	& MEDICAID SERVICES			OMB NO. 0938-039
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		445203	B. WING		03/23/2021
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z 1000 ST LUKE DRIVE NASHVILLE, TN 37205	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF	TION SHOULD BE COMPLETION THE APPROPRIATE DATE
F 710	included Chronic Ro Obstructive Pulmon	0/2020 with diagnoses which espiratory Failure, Chronic eary Disease, End Stage emia, and Type 1 with	F 7 [.]	10	
	dated 3/23/2021 sho	#15's Physician Order Report owed Resident #15 had no air mattress with settings.			
9000		on on 3/23/2021 at 3:11 PM 5 had a specialty air mattress			
	#16 was admitted to diagnoses which inc	al record showed Resident the facility on 12/6/2019 with luded Pressure Ulcer of e 4, and Chronic Respiratory			
	dated 3/23/2021 sho	#16's Physician Order Report wed Resident #16 had no air mattress with settings.			
:		n on 3/23/2021 at 3:12 PM 3 had a specialty air mattress			
‡ [#17 was admitted to the eadmission on 3/9/2	al record showed Resident the facility on 5/20/2020 with 021 with diagnoses which ncy Anemia, Acute and			

Chronic Respiratory Failure with Hypoxia, Chronic

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				OMB I	NO 0938-039
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F 710		ary Disease, Chronic Diastolic Failure, End Stage Renal abetes Mellitus, and	F 7	10			
	dated 3/23/2021 sho	#17's Physician Order Report owed Resident #17 had no air mattress with settings.					
		on on 3/23/2021 at 3:13 PM 7 had a specialty air mattress					
	#18 was admitted to diagnoses which inc Chronic Obstructive Brain Damage, Pers	ral record showed Resident the facility on 3/8/2018 with luded Respiratory Failure, Pulmonary Disease, Anoxic istent Vegetative State, acral Region, Stage 4, and Atrophy.					
	dated 3/23/2021 sho	#18's Physician Order Report wed Resident #18 had no air mattress with settings.					
		n on 3/23/2021 at 3:14 PM 8 had a specialty air mattress					
		al record showed Resident the facility on 2/2/2015 with					

diagnoses which included Chronic Respiratory Failure, Chronic Obstructive Pulmonary Disease,

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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CO	IDER'S PLAN OF CORRECT ORRECTIVE ACTION SHOU FERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 710	Type 2 Diabetes Me	otein-Calorie Malnutrition, ellitus with Diabetic Chronic ronic Diastolic Heart Failure,	F 7 [.]	10			
	dated 3/23/2021 sho	#19's Physician Order Report owed Resident #19 had no air mattress with settings.					
		on on 3/23/2021 at 3:15 PM, 9 had a specialty air mattress					
	#20 was admitted to diagnoses which inc Respiratory Failure, with Heart Failure, S	al record showed Resident the facility on 2/3/2020 with luded Acute and Chronic Hypertensive Heart Disease evere Protein-Calorie scle Wasting and Atrophy.					
	dated 3/23/2021 sho	#20's Physician Order Report wed Resident #20 had no air mattress with settings.					
		n on 3/23/2021 at 3:16 PM, O had a specialty air mattress					
; ,	#21 was admitted to with diagnoses which Respiratory Failure w						

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CENTE	ERS FOR MEDICARE	& MEDICAID SERVICES				OMB N	O. 0938-0391
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		ATE SURVEY DMPLETED
		445203	B. WING			0:	3/23/2021
	PROVIDER OR SUPPLIER			100	EET ADDRESS, CITY, STATE, ZIP CODE 0 ST LUKE DRIVE SHVILLE, TN 37205		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APP	DULD BE	(X5) COMPLETION DATE
F 710	Epilepsy, Hypertens	ng Cerebral Infarction, ive Heart and Chronic Kidney Fallure, Iron Deficiency	F 7	10			
	dated 3/23/2021 sho	#21's Physician Order Report owed Resident #21 had no air mattress with settings.					
		on on 3/23/2021 at 3:17 PM, 1 had a specialty air mattress					
	#22 was admitted to with diagnoses which Respiratory Failure v Malnutrition, Chronic Systolic and Diastolic	al record showed Resident the facility on 12/10/2018 n included Chronic vith Hypoxia, Protein-Calorie Atrial Fibrillation, Combined c Heart Failure, Muscle , Muscle Weakness, and					
	dated 3/23/2021 show	#22's Physician Order Report wed Resident #22 had no air mattress with settings.					
		n on 3/23/2021 at 3:18 PM, 2 had a specialty air mattress					
	Review of the medica	Il record showed Resident					

#23 was admitted to the facility on 3/4/2020 with diagnoses which included Chronic Respiratory

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CENT	EDS EOR MEDICARE	& MEDICAID SERVICES				. 0938-039
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DAT	E SURVEY
		445203	A BUILDING B WING			C 23/2021
NAME OF	PROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CO		2012021
WEST N	MEADE PLACE		10	00 ST LUKE DRIVE ASHVILLE, TN 37205		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 710	Continued From page	ge 14	F 710			
	Pulmonary Disease Severe Protein-Calc	apnia, Chronic Obstructive , Adult Failure to Thrive, orie Malnutrition, Hypertensive				
	Heart Disease, and Hypoglycemia.	Type 2 Diabetes Mellitus with				
	dated 3/23/2021 sho	#23's Physician Order Report owed Resident #23 had no air mattress with settings.				
		on on 3/23/2021 at 3:19 PM, 3 had a specialty air mattress				
	#24 was admitted to diagnoses which incl Failure with Hypoxia,	al record showed Resident the facility on 10/5/2016 with luded Chronic Respiratory Chronic Obstructive Anoxic Brain Damage, and				
	dated 3/23/2021 show	#24's Physician Order Report wed Resident #24 had no air mattress with settings.				
		n on 3/23/2021 at 3:20 PM, 4 had a specialty air mattress				
		al record showed Resident the facility on 3/17/2020 with				

diagnoses which included Chronic Respiratory Failure with Hypercapnia, Persistent Vegetative

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO.	0938-039
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION	COM	E SURVEY IPLETED
		445203	B. WING			C 23/2021
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	- 0011	LOTEGET
WEST M	IEADE PLACE			1000 ST LUKE DRIVE NASHVILLE, TN 37205		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 710	Continued From pa	ge 15	F 71	10		
	State, Muscle Wast Iron Deficiency.	ing and Atrophy, Epilepsy, and				
	dated 3/23/2021 sho	#25's Physician Order Report owed Resident #25 had no air mattress with settings.				
		on on 3/23/2021 at 3:21 PM, !5 had a specialty air mattress				
The state of the s	#26 was admitted to with diagnoses which Respiratory Failure with Obstructive Pulmona Hemiparesis followir Protein-Calorie Maln Diabetes Mellitus with Neuropathy, Hyperte	al record showed Resident the facility on 12/31/2019 h included Chronic with Hypoxia, Chronic ary Disease, Hemiplegia and g Cerebral Infarction, Severe utrition, Epilepsy, Type 2 h Diabetic Autonomic nsive Heart Disease with a, and Vitamin D Deficiency.				
	dated 3/23/2021 sho	#26's Physician Order Report wed Resident #26 had no air mattress with settings.				
5		n on 3/23/2021 at 3:22 PM, 3 had a specialty air mattress				
		I record showed Resident he facility on 6/4/2019 with				

diagnoses which included Chronic Respiratory

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CENTE	RS FOR MEDICARI	- & MEDICAID SERVICES			OMB M	J. 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		ATE SURVEY MPLETED
		445203	B. WING		0;	C 3/23/2021
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		
WEST	EADE DI ACE			1000 ST LUKE DRIVE		
WEST W	IEADE PLACE			NASHVILLE, TN 37205		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
E 710	Continued From no	ao 16	F 71	10		
1-710	Continued From pa	a, Chronic Obstructive	Г/1	10		
	Pulmonary Disease	e, Hypertensive Heart and ease with Heart Failure, Iron				
	Deliciency Alternia,	and Anerma.				
	Boulow of Booldonf	#27's Dhysiaian Order Panert				
	Review of Resident #27's Physician Order Report dated 3/23/2021 showed Resident #27 had no					
		air mattress with settings.				
		on on 3/23/2021 at 3:23 PM, 27 had a specialty air mattress				
	#28 was admitted to diagnoses which ind Failure with Hypoxia Pulmonary Disease, Epilepsy, Type 2 Dia Autonomic Neuropa	cal record showed Resident to the facility on 1/10/2020 with cluded Chronic Respiratory, Chronic Obstructive Persistent Vegetative State, obetes Mellitus with Diabetic thy, Hypertensive Chronic Vitamin D Deficiency.				
	dated 3/23/2021 sho	#28's Physician Order Report wed Resident #28 had no air mattress with settings.				
;		n on 3/23/2021 at 3:24 PM, 8 had a specialty air mattress				
		al record showed Resident the facility on 1/6/2020 with				

diagnoses which included Chronic Obstructive

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO	0, 0938-0391
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	TIPLE CONSTRUCTION DING		ATE SURVEY DMPLETED
		445702	B. WING			C
	DROVIDED OF OURDINED	445203	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE		3/23/2021
NAME OF	PROVIDER OR SUPPLIER			1000 ST LUKE DRIVE	-	
WEST N	MEADE PLACE			NASHVILLE, TN 37205		
040.10	SUMMADVSTA	TEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRE	CTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	PREFIX TAG	X (EACH CORRECTIVE ACTION SHO	OULD BE	COMPLETION DATE
F 710	Continued From pa	ge 17	F 7	10		
	Pulmonary Disease Respiratory Failure					
		Muscle Wasting and Atrophy.				
	dated 3/23/2021 sho	#29's Physician Order Report owed Resident #29 had no air mattress with settings.				į
		on on 3/23/2021 at 3:25 PM, 29 had a specialty air mattress				
Ì	#30 was admitted to with diagnoses whic Respiratory Failure of Obstructive Pulmona	with Hypoxia, Chronic ary Disease, Protein-Calorie I, Type 2 Diabetes Mellitus,				
	dated 3/23/2021 sho	#30's Physician Order Report wed Resident #30 had no air mattress with settings.				
		n on 3/23/2021 at 3:26 PM, 0 had a specialty air mattress		şi.		
	#31 was admitted to	al record showed Resident the facility on 4/4/2019 with uded Acute and Chronic				

Respiratory Failure with Hypoxia, Chronic

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938-039
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED
		445203	B, WING		C 03/23/2021
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE
WEGT	CADE DI ACC			1000 ST LUKE DRIVE	
WEST IN	EADE PLACE			NASHVILLE, TN 37205	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE COMPLETION
F 710	Continued From page	ge 18	F 7′	10	
	Obstructive Pulmon	ary Disease, Hypertensive Heart Failure, and Anemia.			0.
	dated 3/23/2021 sho	#31's Physician Order Report owed Resident #31 had no air mattress with settings.			
		on on 3/23/2021 at 3:27 PM, 11 had a specialty air mattress			
	#32 was admitted to diagnoses which inc Failure with Hypoxia Pulmonary Disease, Stage 4, Pressure U Pressure Ulcer Sacr Ulcer of Left Buttock Hypertensive Chroni Diabetes Mellitus wit	c Kidney Disease, Type 2 h Diabetic Chronic Kidney Chronic Kidney Disease, and			
	dated 3/23/2021 sho	f32's Physician Order Report wed Resident #32 had no air mattress with settings.			
		n on 3/23/2021 at 3:28 PM, 2 had a specialty air mattress			

Review of the medical record showed Resident

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			OMB N	VO. 0938-039
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		DATE SURVEY COMPLETED
		445203	B. WING _			C 03/23/2021
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 1000 ST LUKE DRIVE NASHVILLE, TN 37205	ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 710	diagnoses which inc Failure with Hyperca Pulmonary Disease,	o the facility on 7/10/2019 with cluded Chronic Respiratory apnia, Chronic Obstructive , Hypertensive Chronic Kidney a, Muscle Wasting and	F 71	10		
	dated 3/23/2021 sho	#33's Physician Order Report bwed Resident #33 had no air mattress with settings.				
		on on 3/23/2021 at 3:29 PM, 33 had a specialty air mattress				
:	#34 was admitted to diagnoses which incl Failure with Hypoxia,	ral record showed Resident the facility on 9/4/2020 with luded Chronic Respiratory , Chronic Obstructive Protein-Calorie Malnutrition, nemia.				
(dated 3/23/2021 show	#34's Physician Order Report wed Resident #34 had no air mattress with settings.				
S		n on 3/23/2021 at 3:30 PM, 4 had a specialty air mattress				
#	35 was admitted to t	al record showed Resident the facility on 7/31/2019 with uded Chronic Respiratory				

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			OMB N	0. 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIF	LE CONSTRUCTION		ATE SURVEY DMPLETED
		445203	B WING		0	C 3/23/2021
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
WEST M	EADE PLACE		I I	1000 ST LUKE DRIVE NASHVILLE, TN 37205		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	Disease, Hypertens Failure, Acute and C Protein-Calorie Malr Mellitus with Hypogl Deficiency, Vitamin of other specified B Review of Resident dated 3/23/2021 shounder for a specialty During an observation showed Resident #3 in place. Review of the medic #36 was admitted to diagnoses which incled Pulmonary Disease, with Hypercapnia, Hymercapnia, Hymercap	a, Interstitial Pulmonary ive Heart Disease with Heart Chronic Systolic Heart Failure, nutrition, Type 2 Diabetes ycemia, Anemia, Thiamine D Deficiency, and Deficiency	F 710			
	Chronic Kidney Disea	ase, Anemia in Chronic Deficiency Anemia, and				
(dated 3/23/2021 show	36's Physician Order Report wed Resident #36 had no air mattress with settings.				
		n on 3/23/2021 at 3:32 PM, Shad a specialty air mattress				

in place.

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		& MEDICAID SERVICES				NO. 0938-0391
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL	LTIPLE CONSTRUCTION	(X3)	DATE SURVEY COMPLETED
		445203	B. WING			C 03/23/2021
NAME OF	PROVIDER OR SUPPLIER		'	STREET ADDRESS, CITY, STATE, ZIP C		
WEST	MEADE PLACE			1000 ST LUKE DRIVE NASHVILLE, TN 37205		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL GC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE
F 710	Continued From pag	ge 21	F 7	'10		
	Director of Nursing (Nurse stated all resi a few residents on the air mattress. The Tre resident was on an a have specific setting obtained" The Trea programs the setting mattress according to once the resident wat test (she puts her art ensure the mattress no pressure on the re interview the Treatm put an order for the se flow sheet under gen show up on the Treat for the charge nurses the mattress settings ensure appropriate s Treatment Nurse cor who checked the ma interview the DON ar confirmed all residen	on 3/23/2021 at 2:52 PM, the (DON) and the Treatment dents on the second floor and the third floor had a specialty eatment Nurse stated, "if a air mattress, it needed to it is and a physician order eatment Nurse stated she as for the specialty air to the resident's weight, and as in the bed she did a feel im under the mattress to has appropriate air flow and esident). During further ent Nurse stated she would specialty air mattress on the neral orders, (which does not the thermal orders, (which does not the thermal orders, and she checked is Monday through Friday to ettings for the residents. The offirmed she was the only one thress settings. During further and the Treatment Nurse ts with specialty air nigs had no order for the				

Event ID: D0B811

Attachment A

F 684 Quality of Care

The facility will continue to follow physicians' orders and turn and reposition residents as required as evidenced by:

- 1. The corrective action accomplished for the resident that was affected by the deficient practice was:
 - Resident #2 has had their dental guard in place as per instructions since 3/23/21. Resident has been observed by unit manager or charge nurse at random times, at least 5 times weekly since 3/23/21, with no findings out of compliance with instructions.
 - Resident #2 Order discontinued for isolation.
 - Resident #2 has had their turning and repositioning schedule adhered to since 3/23/21, as evidenced by random checks by wound nurse. Wound nurse or designee has observed residents' position at various times of day, at least 10 observations per week. Resident was found repositioned at each observation.
 - Resident #2 has been observed for heel boot wearing during the same turning and repositioning observations as above. Heel boots were noted to be in place during all observations.
- 2. All residents have the potential to be affected by the deficient practice. The corrective action(s) accomplished for those residents are:
 - All residents with physician orders for mouth guards, isolation, turning and positioning, and heel boots have the potential to be affected by this practice.
 - Currently there are no other residents with orders for mouth guards.
 - There are residents with orders for isolation, but there are no additional residents with physicians' orders for strict isolation with no roommate.
 - Residents that have physician orders for turning and positioning every two hours will be adhered to, however, turning and re-positioning of residents who are unable to do so independently is a standard of care and will be adhered to regardless of the presence or absence of a physician order.
- 3. Steps to ensure the deficient practice does not recur:
 - Nursing Staff will be re-educated on adherence to all physician orders regarding dental guards, wearing pressure relieving boots and floating of heels.

Attachment A

(Continued from Page 1)

- Isolation requirement education by the infection preventionist will be scheduled for all licensed nurses. Education to be completed by 4/21/21.
- Nursing Staff will be re-educated on turning residents every two hours per physicians' orders and facility prevention guidelines. Education to be completed by 4/21/21. Supervisors to monitor compliance daily and compliance to be reported to the DON.
- Contact isolation- isolation orders to be reviewed weekly and clarified as needed.
 Staff to be re-educated on isolation and infection control policies. Education to be completed by 4/21/21.
- 4. The corrective action(s) will be monitored to ensure that the deficient practice will not recur by:
 - Quality assurance monitoring will be conducted regarding following physician orders for pressure relieving boots, dental guards, floating of heels and the turning/repositioning of patients who require assistance. Ten percent of population will be monitored weekly for compliance with physician orders and will be reported to the Director of Nursing or designee. Data will be analyzed monthly and reported to the QA committee monthly by the DON until the QA committee determines compliance has been maintained.

Completion Date: 4/21/21

Attachment B

F 710

Resident's Care Supervised by a Physician

The facility will continue to ensure that the care of each resident is supervised by a physician or by another physician when the attending physician is unavailable as evidenced by:

1. The corrective action(s) accomplished for the residents affected by the deficient practice are:

Physicians' orders will be obtained for a specialty air mattress for each resident identified during the survey. These orders will be placed in each affected residents EHR and will include instruction for responsible nurses to verify settings of specialty air mattresses every shift. The orders for theses mattresses, settings and the monitoring of settings will be accomplished by 4/12/21.

2. All residents have the potential to be affected by the deficient practice. The corrective action(s) accomplished for those residents are:

- There are no additional residents currently on specialty mattresses that were not identified during the survey and the plan of correction for these residents is addressed above.
- New residents admitted to the facility and existing residents not currently on a specialty mattress who may be determined to require a specialty mattress at some future date will be addressed as stated below in #3.

3. Steps to ensure the deficient practice does not recur:

- Physicians Orders will be placed for specialty air mattress with settings and required monitoring of settings upon admission or when it is determined that a specialty mattress is needed for optimal skin integrity.
- Both new and existing orders for residents requiring specialty mattresses will be monitored weekly by treatment nurses for continued compliance and reported to the DON or their designee.
- All licensed nurses will be educated on new air mattress orders and setting observations prior to new order being placed or prior to licensed nurse working first shift after order obtained. All education will be complete by 4/21/21.

4. The corrective action(s) will be monitored to ensure that the deficient practice will not recur by:

The wound nurse will verify proper settings of mattresses on 10 random residents per week and will monitor MARS for compliance with same. Data will be analyzed monthly and reported to the QA committee monthly by the DON until the QA committee determines compliance has been maintained.

Completion Date: 4/21/21